Transfer of Patient Health Information Across the Continuum (2001 update)

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Background

In order to assure continuity of patient care, healthcare providers disclose to subsequent healthcare providers the health information that is necessary to facilitate a smooth transition and efficient and effective care. Such disclosures occur verbally, when a referring physician telephones a consultant, or through the provision of documentation originated by the first provider and sent to the second.

As advances in technology provide for the automation of these information transfers, it is important that members of the health information and information services team understand the data that must be transferred as identified in law, accreditation, or professional practice standards.

Legal and Regulatory Requirements

Federal

The Medicare Conditions of Participation for Hospitals (42 CFR 482.43) state, "The hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies or outpatient services, as needed, for follow-up or ancillary care."

The **Requirements for States and Long Term Care Facilities** state:

- "The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution or record release is required by law." (42 CFR 483.10)
- "In cases of transfer of a resident with mental illness or mental retardation from a nursing facility to a hospital or to another nursing facility, the transferring nursing facility is responsible for ensuring that copies of the resident's most recent PASARR and resident assessment reports accompany the transferring resident." (42 CFR 483.106)

The **Conditions of Participation for Home Health Agencies** state:

- "All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur. A written summary report for each patient is sent to the attending physician at least every 62 days." (42 CFR 484.14)
- "The home health agency must inform the attending physician of the availability of a discharge summary. The discharge summary must be sent to the attending physician upon request and must include the patient's medical and health status at discharge." (42 CFR 484.48)
- "If a patient is transferred to another health facility, a copy of the record or abstract is sent with the patient." (42 CFR 484.48)

The **Conditions of Participation for Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services** state:

- "All patients must be referred to the facility by a physician who provides the following information to the facility before treatment is initiated:

  - the patient's significant medical history
  - current medical findings
  - diagnosis(es) and contraindications to any treatment modality
  - rehabilitation goals, if determined." (42 CFR 485.58)

- "A physician must establish a plan of treatment before the facility initiates treatment . . ." (42 CFR 485.58)

- "The following are obtained by the organization before or at the time of initiation of treatment:

  - the patient's significant past history
  - current medical findings, if any
  - diagnosis(es), if established
  - physician's orders, if any
  - rehabilitation goals, if determined
  - contraindications, if any
  - the extent to which the patient is aware of the diagnosis(es) and prognosis
  - if appropriate, the summary of treatment furnished and results achieved during previous periods of rehabilitation services or institutionalization." (42 CFR, 485.711, Subpart H)

- "In the case of a Critical Access Hospital that is a member of a rural health network as defined in Sec. 485.603 of this chapter, the Critical Access Hospital has in effect an agreement with at least one hospital that is a member of the network for

  - patient referral and transfer
  - the development and use of communications systems of the network, including the network's system for the electronic sharing of patient data, and telemetry and medical records, if the network has in operation such a system." (42 CFR 485.616)

The federal government, in the standards for privacy of individually identifiable health information, more commonly referred to as the HIPAA privacy rule (45 CFR, Parts 160 through 164), permits use and disclosure of protected health information pursuant to and in compliance with a consent to carry out treatment, payment or healthcare operations (164.502).

In section 164.506, the rule outlines exceptions that might apply to the transfer of information between one healthcare provider and the next, including:

- the covered healthcare provider created or received the protected health information in the course of providing healthcare to an individual who is an inmate
- emergency treatment situations, if the covered healthcare provider attempts to obtain such consent as soon as reasonably practicable after the delivery of such treatment
- the covered healthcare provider is required by law to treat the individual and attempts to obtain such consent but is unable to obtain such consent; or
- if a covered healthcare provider attempts to obtain such consent from the individual but is unable to obtain such consent due to substantial barriers to communicating with the individual and provider determines that the individual's consent to receive treatment is clearly inferred from the circumstances

If the covered healthcare provider fails to obtain such consent, attempts to obtain consent and the reason why consent was not obtained must be documented.

State

Individual states may also have laws or regulations that require one healthcare provider to provide specific health information to another caring for a patient.

Accreditation Standards

Standard CC.7 in the Joint Commission's *Comprehensive Accreditation Manual for Hospitals* states, "The hospital ensures that appropriate patient care and clinical information is exchanged when patients are admitted, referred, transferred, or discharged." The corresponding statement of intent says, "Patient information shared with other providers consists of relevant information, including: the reason for transfer, referral, or discharge; the patient's physical and psychosocial status; a summary of care provided and progress toward goals; and community resources or referrals provided to the patient."

In the Joint Commission's *2000-2001 Comprehensive Accreditation Manual for Ambulatory Care,* standard CC.7 states, "Appropriate patient care and clinical information are exchanged when patients enter or are admitted, referred, transferred, or discharged. The corresponding intent statement says, "Patient information shared with other providers consists of relevant information, including: the reason for transfer, referral, or discharge; the patient's physical and psychosocial status; a summary of care provided and progress toward goals; and instruction or referrals provided to the patient."

Standard CC.6 in the Joint Commission's *2000-2001 Comprehensive Accreditation Manual for Long Term Care* states, "When residents are discharged, the organization communicates appropriate information to subsequent providers." Standard IM.7.5 states, "Discharge information is provided to the resident or to the receiving organization." The corresponding intent statement continues, "The organization provides relevant information to the resident, family, or another entity accepting the resident when the resident is transferred or discharged. The information includes:

- medical findings, diagnosis(es), and treatment orders
- a summary of the care and services provided and progress toward achieving goals
- diet orders and medication orders
- behavioral status, ambulation status, nutrition status, and rehabilitation potential
- the resident's physical and psychosocial status
- nursing information useful in resident care
- advance directives
- referrals provided to the resident
- the reason for transfer, discharge, or referral
- the physician's orders for the resident's immediate care
- instructions given to the resident before discharge
- the referring physician's name
- and the physician who has agreed to be responsible for the resident's medical care and treatment, if other than the referring physician"

In the Joint Commission's *1999-2000 Comprehensive Accreditation Manual for Home Care*, standard CC.4.3.1 states, "As appropriate to the scope of care or services, the organization provides the responsible physician with information on the patient's condition, the outcome of current treatment, and the patient's response." In the corresponding intent statement, the manual also states, "There is ongoing communication between organization staff and the patient's physician, or between the hospice interdisciplinary team and the patient's physician. The organization defines the frequency of and process for such communication. Staff or hospice interdisciplinary team members provide the physician with information on the patient's current condition, changes in the patient's condition, the outcome of care and services, the patient's response to current treatment and medication, changes in caregiver support or the environment, or results of relevant laboratory tests when they become available."

In addition, standard CC.5.2 states, "Appropriate patient information is exchanged when the patient is referred, transferred, or discharged." In the corresponding statement of intent, the manual states, "To facilitate continuity of care or services, the organization communicates appropriate patient information to any health care organization or provider to which the patient is referred, transferred or discharged. . . . Relevant information includes, when appropriate, the reason for transfer, referral, or discharge, the patient's physical and psychosocial status at the time of transfer, a summary of the care or services provided and progress toward goals, instruction and referrals provided to the patient, and the existence of any advance directives. The physician(s) who ordered care or service is notified of the patient's discharge. When required by law and regulation, written discharge summaries are provided to the patient's physician. . . . When a hospice patient is transferred from home care to inpatient service, or vice versa, the service transferring the patient provides a summary including the care or services provided,

specific medical, psychosocial, or other problems requiring intervention or follow-up, and any follow-up to be provided by an interdisciplinary team member from the service that is transferring the patient."

Standard CC.5 in the Joint Commission's *1998-2000 Comprehensive Accreditation Manual for Health Care Networks* states, "The network facilitates timely communication of information among components and practitioner sites to support continuity of care." The corresponding intent statement says, "Information necessary to provide continuity of care is given to any healthcare component or practitioner or other clinical care site to which the member is admitted, referred, transferred, or discharged. The network provides the receiving component or practitioner site with relevant member information including care requested, the reason for changing the site of care, a summary of care provided and progress toward achieving goals, and instructions or referrals provided to the member."

The Accreditation Association for Ambulatory Care's *Accreditation Handbook for Ambulatory Care 2000* requires that, "When necessary for ensuring continuity of care, summaries or records of a patient who was treated elsewhere (such as by another physician, hospital, ambulatory surgical service, nursing home, or consultant) are obtained." In addition, "When necessary for ensuring continuity of care, summaries of the patient's record are transferred to the health care practitioner to whom the patient was transferred and, if appropriate, to the organization where future care will be rendered."

Recommendations

In order to ensure continuity of care, healthcare providers should:

- identify existing state requirements relative to the transfer of information between providers
- establish policies and procedures to facilitate appropriate provision of patient health information when referring, transferring or discharging patients (See "Minimum Data Requirements for Most Common Transfers," below) obtain a consent to disclose information to a subsequent healthcare provider via the consent for treatment, payment, and operations and notice of information practices process required in the HIPAA privacy rule (See AHIMA's practice brief on Consent for the Use or Disclosure of Individually Identifiable Health Information, May 2001.)
- educate staff as to policies and procedures for transferring information to other healthcare providers
- audit processes against established policies and procedures and implement corrective action when indicated

Minimum Data Requirements for Most Common Transfers

Transfer to	**Acute**	**Ambulatory**	**Long-term**	**Home Health**
From Acute	"The hospital must transfer or refer patients, along with necessary medical information to appropriate facilities, agencies or outpatient services, as needed, for follow-up or ancillary care." (42 CFR 482.43) "The hospital ensures that appropriate patient care and clinical information is exchanged when	"The hospital must transfer or refer patients, along with necessary medical information to appropriate facilities, agencies or outpatient services, as needed, for follow-up or ancillary care." (42 CFR 482.43) "The hospital ensures that appropriate patient care and clinical information is exchanged when	"The hospital must transfer or refer patients, along with necessary medical information to appropriate facilities, agencies or outpatient services, as needed, for follow-up or ancillary care." (42 CFR 482.43) "The hospital ensures that appropriate patient care and clinical information is	"The hospital must transfer or refer patients, along with necessary medical information to appropriate facilities, agencies or outpatient services, as needed, for follow-up or ancillary care." (42 CFR 482.43) "The hospital ensures that appropriate patient care and clinical information is

	patients are admitted, referred, transferred, or discharged." The corresponding intent statement says, "Patient information shared with other providers consists of relevant information, including: the reason for transfer, referral, or discharge; the patient's physical and psychosocial status; a summary of care provided and progress toward goals; and community resources or referral provided to the patient." (Joint Commission standard CC.7)	patients are admitted, referred, transferred, or discharged." The corresponding intent statement says, "Patient information shared with other providers consists of relevant information, including: the reason for transfer, referral, or discharge; the patient's physical and psychosocial status; a summary of care provided and progress toward goals; and community resources or referral provided to the patient." (Joint Commission standard CC.7) "When necessary for ensuring continuity of care, summaries or records of a patient who was treated elsewhere are obtained." (AAAHC)	exchanged when patients are admitted, referred, transferred, or discharged." The corresponding intent statement says, "Patient information shared with other providers consists of relevant information, including: the reason for transfer, referral, or discharge; the patient's physical and psychosocial status; a summary of care provided and progress toward goals; and community resources or referral provided to the patient." (Joint Commission standard CC.7)	exchanged when patients are admitted, referred, transferred, or discharged." The corresponding intent statement says, "Patient information shared with other providers consists of relevant information, including: the reason for transfer, referral, or discharge; the patient's physical and psychosocial status; a summary of care provided and progress toward goals; and community resources or referral provided to the patient." (Joint Commission standard CC.7)

Minimum Data Requirements for Most Common Transfers

Transfer to	Acute	Ambulatory	Long-term	Home Health
From Ambulatory	"Appropriate patient care and clinical information are exchanged when patients enter or are admitted, referred, transferred, or discharged." The corresponding intent statement says, "Patient information shared with other providers consists of relevant information,	"Appropriate patient care and clinical information are exchanged when patients enter or are admitted, referred, transferred, or discharged." The corresponding intent statement says, "Patient information shared with other providers consists of relevant information,	"Appropriate patient care and clinical information are exchanged when patients enter or are admitted, referred, transferred, or discharged." The corresponding intent statement says, "Patient information shared with other providers consists of relevant information,	"Appropriate patient care and clinical information are exchanged when patients enter or are admitted, referred, transferred, or discharged." The corresponding intent statement says, "Patient information shared with other providers consists of relevant information,

	including: the reason for transfer, referral, or discharge; the patient's physical and psychosocial status; a summary of care provided and progress toward goals; and instruction or referrals provided to the patient." (Joint Commission standard CC.7)	including: the reason for transfer, referral, or discharge; the patient's physical and psychosocial status; a summary of care provided and progress toward goals; and instruction or referrals provided to the patient." (Joint Commission standard CC.7) "When necessary for ensuring continuity of care, summaries or records of a patient who was treated elsewhere are obtained . . . are transferred to the health care practitioner to whom the patient was transferred and, if appropriate, to the organization where future care will be rendered." (AAAHC)	including: the reason for transfer, referral, or discharge; the patient's physical and psychosocial status; a summary of care provided and progress toward goals; and instruction or referrals provided to the patient." (Joint Commission standard CC.7)	including: the reason for transfer, referral, or discharge; the patient's physical and psychosocial status; a summary of care provided and progress toward goals; and instruction or referrals provided to the patient." (Joint Commission standard CC.7)

Minimum Data Requirements for Most Common Transfers

Transfer to	Acute	Ambulatory	Long-term	Home Health
From Long-term	"In cases of transfer of a resident with mental illness or mental retardation to a hospital or to another nursing facility, the transferring nursing facility is responsible for ensuring that copies of the resident's most	"When residents are discharged, the organization communicates appropriate information to subsequent providers." (Joint Commission standard CC.6)	"In cases of transfer of a resident with mental illness or mental retardation to a hospital or to another nursing facility, the transferring nursing facility is responsible for ensuring that copies of the resident's	"When residents are discharged, the organization communicates appropriate information to subsequent providers." (Joint Commission standard CC.6)

	recent PASARR and resident assessment reports accompany the transferring resident." (42 CFR 484.14) "When residents are discharged, the organization communicates appropriate information to subsequent providers." (Joint Commission standard CC.6) "Discharge information is provided to the resident or to the receiving organization." The corresponding intent statement says, "The organization provides relevant information to the resident, family, or other entity accepting the resident when the resident is transferred or discharged. The information includes: medical findings, diagnosis(es), and treatment orders; a summary of the care and services provided and progress toward achieving goals; diet orders and medication orders; behavioral status, ambulatory status, nutritional status, and rehabilitation potential; the resident's physical and psychosocial status; nursing information useful in	"When necessary for ensuring continuity of care, summaries or records of a patient who was treated elsewhere are obtained." (AAAHC)	most recent PASARR and resident assessment reports accompany the transferring resident." (42 CFR 484.14) "When residents are discharged, the organization communicates appropriate information to subsequent providers." (Joint Commission standard CC.6) "Discharge information is provided to the resident or to the receiving organization." The corresponding intent statement says, "The organization provides relevant information to the resident, family, or other entity accepting the resident when the resident is transferred or discharged. The information includes: medical findings, diagnosis(es), and treatment orders; a summary of the care and services provided and progress toward achieving goals; diet orders and medication orders; behavioral status, ambulatory status, nutritional status, and rehabilitation potential; the resident's physical and psychosocial	"Discharge information is provided to the resident or to the receiving organization." The corresponding intent statement says, "The organization provides relevant information to the resident, family, or other entity accepting the resident when the resident is transferred or discharged. The information includes: medical findings, diagnosis(es), and treatment orders; a summary of the care and services provided and progress toward achieving goals; diet orders and medication orders; behavioral status, ambulatory status, nutritional status, and rehabilitation potential; the resident's physical and psychosocial status; nursing information useful in resident care; advance directives; referrals provided to the resident; the reason for transfer, discharge or referral; the physician's orders for the resident's immediate care; instructions given to the resident before discharge; the referring physician's name; and the physician who has

	resident care; advance directives; referrals provided to the resident; the reason for transfer, discharge or referral; the physician's orders for the resident's immediate care; instructions given to the resident before discharge; the referring physician's name; and the physician who has agreed to be responsible for the resident's medical care and treatment, if other than the referring physician." (Joint Commission standard IM 7.5)		status; nursing information useful in resident care; advance directives; referrals provided to the resident; the reason for transfer, discharge or referral; the physician's orders for the resident's immediate care; instructions given to the resident before discharge; the referring physician's name; and the physician who has agreed to be responsible for the resident's medical care and treatment, if other than the referring physician." (Joint Commission standard IM 7.5)	agreed to be responsible for the resident's medical care and treatment, if other than the referring physician." (Joint Commission standard IM 7.5)

Minimum Data Requirements for Most Common Transfers

Transfer to	Acute	Ambulatory	Long-term	Home Health
From Home Health	"If a patient is transferred to another health facility, a copy of the record or abstract is sent with the patient." (42 CFR 484.48) "Appropriate patient information is exchanged when the patient is referred, transferred, or discharged." (Joint Commission Standard	"A written summary report for each patient is sent to the attending physician at least every 62 days." (42 CFR 484.14) "The Home Health Agency must inform the attending physician of the availability of a discharge summary. The discharge summary must be	"If a patient is transferred to another health facility, a copy of the record or abstract is sent with the patient." (42 CFR 484.48) "Appropriate patient information is exchanged when the patient is referred, transferred, or discharged." (Joint Commission Standard	"If a patient is transferred to another health facility, a copy of the record or abstract is sent with the patient." (42 CFR 484.48) "Appropriate patient information is exchanged when the patient is referred, transferred, or discharged." (Joint Commission Standard

	CC.5.2) In the corresponding statement of intent, the manual says, "The organization communicates appropriate patient information to any health care organization or provider to which the patient is referred, transferred or discharged....Relevant information includes, when appropriate the reason for transfer, referral, or discharge; the patient's physical and psychosocial status at the time of transfer; a summary of the care or services provided and progress toward goals; instruction and referrals provided to the patient; and the existence of any advance directives. ...When a hospice patient is transferred from home care to inpatient service, or vice versa, the service transferring the patient provides a summary including: the care or services provided, specific medical, psychosocial, or other problems requiring intervention or follow-up; and any follow-up to be provided by an inter-disciplinary team member from the service that is transferring the patient."	sent to the attending physician upon request and must include the patient's medical and health status at discharge." (42 CFR 484.48) "As appropriate to the scope of care or services, the organization provides the responsible physician with information on the patient's condition, the outcome of current treatment and the patient's response." In the corresponding intent statement, the manual states, "There is ongoing communication between organization staff and the patient's physician, or between the hospice interdisciplinary team and the patient's physician. The organization defines the frequency of and process for such communication. Staff or hospice interdisciplinary team members provide the physician with information on: the patient's current condition; changes in the patient's condition; the outcome of care and services; the patient's response to current treatment and medication; changes in caregiver support or the environment; or results of relevant laboratory rests when they become available." (Joint	CC.5.2) In the corresponding statement of intent, the manual says, "The organization communicates appropriate patient information to any health care organization or provider to which the patient is referred, transferred or discharged....Relevant information includes, when appropriate the reason for transfer, referral, or discharge; the patient's physical and psychosocial status at the time of transfer; a summary of the care or services provided and progress toward goals; instruction and referrals provided to the patient; and the existence of any advance directives. ...When a hospice patient is transferred from home care to inpatient service, or vice versa, the service transferring the patient provides a summary including: the care or services provided, specific medical, psychosocial, or other problems requiring intervention or follow-up; and any follow-up to be provided by an inter-disciplinary team member from the service that is transferring the patient."	CC.5.2) In the corresponding statement of intent, the manual says, "The organization communicates appropriate patient information to any health care organization or provider to which the patient is referred, transferred or discharged....Relevant information includes, when appropriate the reason for transfer, referral, or discharge; the patient's physical and psychosocial status at the time of transfer; a summary of the care or services provided and progress toward goals; instruction and referrals provided to the patient; and the existence of any advance directives."

		Commission Standard CC4.3.1) "Appropriate patient information is exchanged when the patient is referred, transferred, or discharged." (Joint Commission Standard CC.5.2) In the corresponding statement of intent, the manual says, "The organization communicates appropriate patient information to any health care organization or provider to which the patient is referred, transferred or discharged....Relevant information includes, when appropriate the reason for transfer, referral, or discharge; the patient's physical and psychosocial status at the time of transfer; a summary of the care or services provided and progress toward goals; instruction and referrals provided to the patient; and the existence of any advance directives. The physician(s) who ordered care or service is notified of the patients discharge. When required by law and regulation, written discharge summaries are provided to the patient's physician." "When necessary for ensuring continuity of care, summaries or			

		records of a patient who was treated elsewhere are obtained." (AAAHC)		

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